Filed 10/23/12 Ghazibayat v. Cal. Dept. of Health Services CA2/2

**NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS**



IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION TWO

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| NIKROUZ GHAZIBAYAT,<br><br>Plaintiff and Appellant,<br><br>v.<br><br>CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES,<br><br>Defendant and Respondent. | B239705<br><br>(Los Angeles County Super. Ct. No. BC441746) |

APPEAL from a judgment of the Superior Court of Los Angeles County. Ann I. Jones, Judge. Affirmed.

Nikrouz Ghazibayat, in pro. per., for Plaintiff and Appellant.

Kamala D. Harris, Attorney General, Julie Weng-Gutierrez, Assistant Attorney General, Richard T. Waldow and Gregory M. Cribbs, Deputy Attorneys General, for Defendant and Respondent.

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Plaintiff and appellant Nikrouz Ghazibayat sought reimbursement for out-of-pocket medical expenses he incurred between 1992 and 2001. The California Department of Health Care Services (Department) denied his claim and an administrative decision sustained that denial. The trial court denied appellant's petition for writ of administrative mandamus challenging the decision.

We affirm. Substantial evidence supported the determination that appellant was not entitled to reimbursement because he offered inadequate proof of his medical expenses.

## FACTUAL AND PROCEDURAL BACKGROUND

***Medi-Cal Reimbursement.***

With the enactment of title XIX of the Social Security Act (42 U.S.C. § 1396), Congress established Medicaid, a cooperative federal-state program designed to provide necessary medical care to poor individuals who had previously been denied access to such care. (*Conlan v. Bontá* (2002) 102 Cal.App.4th 745, 753 (*Conlan I*).) Medi-Cal is California's Medicaid program, administered by the Department. (*Ibid*.) "State participation in Medicaid is voluntary but if a state participates, it must comply with the federal statutes and regulations governing the programs. [Citation.]" (*Ibid*.) In *Conlan I*, the court determined that federal law required the Department to implement procedures by which Medi-Cal beneficiaries could obtain reimbursement for out-of-pocket medical expenses incurred during the "retroactivity period"—the three-month period before a qualifying individual applies for reimbursement benefits. (*Id.* at pp. 753, 761–762.)

Three years later in *Conlan v. Shewry* (2005) 131 Cal.App.4th 1354, 1386 (*Conlan II*), the appellate court affirmed an order disapproving the Department's proposed reimbursement plan. Among other matters, the *Conlan II* court determined that only expenses incurred on or after June 27, 1997 were reimbursable and that reimbursement also extended to the evaluation period when a Medi-Cal application is under consideration. (*Id*. at pp. 1377–1380.)

Thereafter, the Department submitted a "Revised Plan for Beneficiary Reimbursement" (*Conlan* plan) which the trial court approved. According to the *Conlan* plan, reimbursement claimants must satisfy several enumerated criteria, including showing Medi-Cal eligibility, lack of previous reimbursement and lack of other health coverage. Another required criterion is that "[t]he beneficiary has submitted a valid claim which includes dated proof of payment by the beneficiary or another person on behalf of the beneficiary, for the service(s) received (cancelled check, provider receipts, etc.) with an itemized list of services covered by the payments and to whom the payment was made." This requirement is in addition to the requirement of showing medical necessity if Medi-Cal authorization would have been required for the service.

***Appellant's Reimbursement Claim is Denied.***

Pursuant to the *Conlan* plan, during the first quarter of 2007 the Department sent letters to current and former Medi-Cal recipients, including appellant, notifying them that they may be eligible for reimbursement of medical or dental bills they had paid. The notice explained the criteria for reimbursement, and indicated, among other requirements, that claimants must show they received a medically necessary service during the relevant time period and must be able to provide proof of payment. Appellant received his notice in late February or early March 2007.

On March 2, 2007, appellant telephoned the Department, stating that he did not understand why the Department needed proof of payment instead of just taking him at his word. Later, on March 21, 2007, appellant again telephoned the Department, stating that he did not have proof of payment and that he intended to file a lawsuit if he was not reimbursed. He requested something in writing from the Department stating that it would not pay without proof of payment; the Department advised appellant that if he filed a claim without proof of payment, he would receive a denial in writing. Appellant telephoned the Department several other times throughout June, July and August 2007, but did not submit a *Conlan* claim during that time period.

On November 16, 2007, appellant submitted a *Conlan* claim, seeking reimbursement for medical expenses incurred between 1992 and 2007 for services

rendered by Mohsen T. Moghaddam, M.D. In support of his claim he submitted a letter from Dr. Moghaddam which stated that appellant had been under his care since 1992, received treatments once per month, did not have medical insurance and paid out of pocket for medications listed in the letter and for supplies.

The Department initially responded in December 2007, stating that appellant's claim lacked certain information required for processing, including proof of payment for Dr. Moghaddam; itemized billing statements showing dates of service, procedure codes and amount paid out of pocket to Dr. Moghaddam; and a completed payee data record. Appellant responded by submitting a handwritten declaration which stated: "I have paid for my medications and copayment[s] to my doctor out of my own pocket—entirely—till in 2001 . . . it was taken over by [Medi-Cal]." He also submitted a product price list from Rite Aid pharmacy which identified five medications with their brand price and, if available, generic price. He also submitted a payee data record.

In June 2008, the Department denied the claim. After noting that appellant had been sent a letter in December 2007 requesting additional information, the Department stated: "Per your conversation on 06/06/08 you stated that you did not have anymore [*sic*] documentation to provide and that you did not want to receive anymore [*sic*] letters requesting additional information. Your claim is not complete without the requested information."

Following the denial, an Administrative Law Judge (ALJ) held a hearing on October 15, 2008. In a position statement filed in connection with the hearing, the Department confirmed its denial of the claim on the bases that appellant did not submit any proof of payment of out-of-pocket expenses or identify the total amount sought, and his eligibility for Medi-Cal was limited to the time periods February through December 1999, January 2001 and April to November 2001. At the hearing, however, appellant submitted a 13-page "Patient Drug History" prepared by a pharmacy for the period January 2005 to October 2008. The Department indicated it would consider appellant's submission and reevaluate his claim.

The ALJ issued a decision the following day, which confirmed the Department's agreement to reevaluate appellant's request for reimbursement of out-of-pocket medical expenses and directed the Department to conduct its reevaluation pursuant to *Conlan II, supra*, 131 Cal.App.4th 1354. After doing so, the Department issued another denial in January 2009, and appellant requested a rehearing.

At a second hearing on July 7, 2009, appellant offered into evidence his letter from Dr. Moghaddam, the Rite Aid pharmacy price list, the patient drug history and a 1991 letter from M. J. Dragan, M.D., outlining how many times appellant had seen him between 1986 and 1991. In addition to receiving those items, the ALJ summarized appellant's testimony: "The claimant noted that he has been disabled since the 1980's and provided evidence that he was awarded Social Security disability benefits in 1983. He testified that he was awarded Social Security disability benefits retroactively to 1992 and received a lump sum disability payment in excess of $37.000. [¶] He testified that he had paid for medications and other medical bills out of pocket from 1992 through March 2001. He testified that he has no receipts from medical expenses 10 to 15 years ago and contended that he was not required to produce any receipts."

After summarizing the holdings of *Conlan I* and *Conlan II* and identifying the criteria for processing reimbursement claims, the ALJ ruled: "[T]he claimant has substantial disabilities and has made out of pocket expenditures during the period in question. However, claims filed under the court-approved *Conlan* Beneficiary Reimbursement Plan must meet certain criteria in order to qualify for reimbursement, and the ALJ has no authority to disregard these criteria. [¶] . . . [¶] The *Conlan* court order only applies beginning on June 27, 1997 so any claims for reimbursement prior to June 27, 1997 cannot be considered. While there was a dispute as to whether the claimant was eligible for Medi-Cal during June 27, 1997 through March 2001, the claimant did not provide receipts or cancelled checks for specific medications or services. Without such documentation, there cannot be reimbursement for medical expenses even if the claimant did pay for such expenses out of his pocket. [¶] Based on these findings,

it must be determined that the claimant's claim for reimbursement does not meet the criteria of the Beneficiary Reimbursement Plan." Accordingly, the ALJ denied the claim.

In July 2010, appellant filed a complaint requesting judicial review under Code of Civil Procedure section 1094.5.[1] After the matter was transferred to the writs and receivers department, appellant sought retransfer for the purpose of holding a jury trial on his complaint. After denying that procedural request, the trial court construed appellant's complaint as a petition for writ of mandamus and denied it in its entirety, entering judgment in favor of the Department.

This appeal followed.

## DISCUSSION

Appellant contends the judgment should be reversed, asserting that he made a sufficient showing entitling him to reimbursement. We disagree.

### I. Standard of Review.

Under section 1094.5, subdivision (c), the trial court's review of an adjudicatory administrative decision is subject to two possible standards of review, depending upon the nature of the right involved. (*Wences v. City of Los Angeles* (2009) 177 Cal.App.4th 305, 313.) If the administrative decision involves or substantially affects a fundamental vested right, the trial court must exercise its independent judgment in evaluating the evidence. (*Ibid.*) "If, on the other hand, the administrative decision neither involves nor substantially affects a fundamental vested right, the trial court's review is limited to determining whether the administrative findings are supported by substantial evidence. [Citations.]" (*Ibid.*) In *Cooper v. Kizer* (1991) 230 Cal.App.3d 1291, 1299, the court concluded that "the right of a disabled applicant to Medi-Cal benefits is fundamental. Like the applicant for public assistance, the disabled applicant for medical benefits is in

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[1] Unless otherwise indicated, all further statutory references are to the Code of Civil Procedure.

need because of deterioration in his or her life situation. [Citation.]" (But see *Pacific Coast Medical Enterprises v. Department of Benefit Payments* (1983) 140 Cal.App.3d 197, 208 [holding health care provider PCME "had no *vested* right to reimbursement. Its application for such reimbursement was not unlike an application for any other governmental benefit, and the determination respecting PCME's eligibility for such reimbursement is the type of decision as to which courts have traditionally deferred to the administrative agency's expertise by applying the substantial evidence test on review"].)

Nonetheless, "[r]egardless of the nature of the right involved or the standard of judicial review applied in the trial court, an appellate court reviewing the superior court's administrative mandamus decision always applies a substantial evidence standard. [Citations.]" (*JHK Enterprises, Inc. v. Department of Industrial Relations* (2006) 142 Cal.App.4th 1046, 1058.) "[D]epending on whether the trial court exercised independent judgment or applied the substantial evidence test, the appellate court will review the record to determine whether either the trial court's judgment or the agency's findings, respectively, are supported by substantial evidence. [Citation.]" (*Ibid*.) Where the trial court exercised its independent judgment, we will review the trial court's decision for substantial evidence. (*Ibid.*) On the other hand, if the trial court employed the substantial evidence test because no fundamental vested right was involved, then our function is the same as that of the trial court: We review "the administrative record to determine whether the agency's findings were supported by substantial evidence, resolving all conflicts in the evidence and drawing all inferences in support of them." (*Ibid.*; accord, *Desmond v. County of Contra Costa* (1993) 21 Cal.App.4th 330, 334–335.)

## II. Appellant Has Failed to Demonstrate Any Reversible Error.

"'"A judgment or order of the lower court is *presumed correct.* All intendments and presumptions are indulged to support it on matters as to which the record is silent, and error must be affirmatively shown. This is not only a general principle of appellate practice but an ingredient of the constitutional doctrine of reversible error." [Citation.]' [Citations.] 'A necessary corollary to this rule is that if the record is inadequate for

meaningful review, the appellant defaults and the decision of the trial court should be affirmed.' [Citations.]" (*Gee v. American Realty & Construction, Inc*. (2002) 99 Cal.App.4th 1412, 1416 (*Gee*); see also *Estrada v. Ramirez* (1999) 71 Cal.App.4th 618, 620, fn. 1 ["It is the burden of appellant to provide an accurate record on appeal to demonstrate error. Failure to do so precludes an adequate review and results in affirmance of the trial court's determination"].)

Here, although *Cooper v. Kizer, supra,* 230 Cal.App.3d at page 1299 provides support for the notion that the trial court was obligated to independently review the administrative decision, we are unable to ascertain the nature of the trial court's review because the judgment is silent as to the trial court's reasons for its decision and the record does not contain a reporter's transcript of the proceedings. Indeed, appellant failed to request that a reporter's transcript be prepared and thus failed to satisfy his burden to furnish an adequate record for review.[2] (See *Hearn v. Howard* (2009) 177 Cal.App.4th 1193, 1200.) We are therefore guided by the same conclusion reached in *Gee*, *supra*, 99 Cal.App.4th at page 1416, where the appellant failed to provide a reporter's transcript of the hearing on the motion he challenged on appeal, and the appellate court determined that so long as possible grounds existed for the trial court's decision the appellant failed to overcome the ruling's presumption of correctness. (Accord, *Hearn v. Howard*, *supra*, 177 Cal.App.4th at p. 1201 [where appellant failed to provide a reporter's transcript of challenged hearing, appellate court was required to "presume that what occurred at that hearing supports the judgment"].)

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[2] We recognize that appellant has represented himself throughout these proceedings. His pro. per. status, however, does not excuse his compliance with basic principles of appellate procedure. (E.g., *Rappleyea v. Campbell* (1994) 8 Cal.4th 975, 984–985 ["[M]ere self-representation is not a ground for exceptionally lenient treatment. Except when a particular rule provides otherwise, the rules of civil procedure must apply equally to parties represented by counsel and those who forego attorney representation"]; *Kobayashi v. Superior Court* (2009) 175 Cal.App.4th 536, 543 ["Pro. per. litigants are held to the same standards as attorneys"].)

Nonetheless, on the basis of the record before us, we conclude substantial evidence supported the judgment. The trial court stated that it had considered the papers filed as well as the administrative record. The documents considered included letters from two of appellant's doctors stating that appellant had received regular treatment and been prescribed certain medications during the relevant time period, appellant's declaration that he paid for his doctors' co-payments and his medications out of his own pocket, a Rite Aid product price list and a patient drug history which identified appellant's cost for medications purchased between 2005 and 2008. The administrative record also contained a transcript of the administrative hearing during which appellant testified that he had no receipts or any other proof of payment.

This evidence—even when considered cumulatively—failed to satisfy appellant's burden to show proof of payment. Neither the doctors' letters nor appellant's declaration contained any dollar amount; nor did they specify an itemized list of the services provided. While the Rite Aid product price list identified a dollar amount for certain medications, there was no additional evidence to show when and in what quantity appellant had purchased such medications. Finally, the medications listed in appellant's patient drug history were prescribed during a three-year time period beyond the end of the 2001 reimbursement period. Thus, substantial evidence supported the trial court's refusal to vacate the administrative decision sustaining the denial of appellant's claim.

We reject appellant's contention that it was sufficient for him to show that he was under a doctor's care and paid for medical services and medications. As the administrative decision here highlighted, the *Conlan* plan requires specified proof. (See *Conlan II, supra,* 131 Cal.App.4th at p. 1385 [through the *Conlan* plan, the Department is not obligated to ensure that all beneficiaries are made whole].) In order to be entitled to reimbursement, a claimant must follow the court-approved procedures, one being that a valid claim be submitted "which includes dated proof of payment by the beneficiary or another person on behalf of the beneficiary, for the service(s) received (cancelled check, providers receipts, etc.) with an itemized list of services covered by the payment and to whom the payment was made." Appellant's evidence did not satisfy this requirement.

We likewise reject appellant's contention that it was sufficient for him to offer evidence of medical necessity. Dr. Moghaddam's statements addressed a separate requirement under the *Conlan* plan for Medi-Cal services that would have required prior Medi-Cal authorization; in those instances the claimant is required to provide "documentation from the medical or dental provider that shows medical necessity for the service(s)." Because appellant failed to satisfy the proof of payment requirement, we need not resolve whether his evidence was sufficient to show medical necessity under the *Conlan* plan.

**DISPOSITION**

The judgment is affirmed. The Department is entitled to its costs on appeal.

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_____, Acting P. J.

DOI TODD

We concur:

_____, J.

ASHMANN-GERST

_____, J.

CHAVEZ